Initial HIV/AIDS Referral
DSN Board/ Provider agency

Use this form to make an initial referral/ notification to DDSN of any service recipient who has been diagnosed HIV+/ AIDS

Name of Consumer:_____

County:_____ Provider Agency:_____

Living Situation: _____

(Home, SLP I, SLP II, CTH I, CTH II, ICF, etc.)

Address: _____

Sex: _____ Date of Birth: _____ Race: _____

Minor? _____ Legal Guardian?_____ Family Involved?_____

Services Currently Receiving:

_____

_____

_____

_____

Name/Title of Contact Person/ Service Coordinator Assigned:

_____

_____

Contact Person's phone #:_____

_____ _____

Executive Director's Name (please print) **Executive Director's signature/date**

(Send this form to the DDSN Director, Division of Quality Assurance)